ALBERTA HEALTH FACILITIES REVIEW COMMITTEE

ANNUAL REPORT 1987

88-05070/

MEMBERS OF THE COMMITTEE 1987

Chairman:	Alan W. Hyland, MLA. (Cypress-Redcliff)	Edmonton
Vice Chairman and Complaints Co-ordinator	Colleen Wood	Edmonton
Members:	Ed Andersen	Marwayne (Term completed Oct. 1987)
	Bert Berube	Leduc (Appointed Nov. 1987)
	Doug Cherry, MLA (Lloydminster)	Lloydminster (Appointed Apr. 1987)
	Betty Biddell	Medicine Hat (Term completed Mar. 1987)
	Brian Elliott	Grande Prairie (Term completed Oct. 1987)
	Marsha Graham	Calgary
	Carol Losie	Edmonton
	Bernice McManus	Calgary
	Carolyn Mick	Innisfail
	Dianne Mirosh, MLA (Calgary Glenmore)	Calgary (Term completed Apr. 1987)
	Abe Remtulla	Calgary
	Sheila Stilling	Grande Prairie (appointed Nov. 1987)
	Mollie Warring	Edmonton
	Sheila Torsher	Bow Island (appointed Nov. 1987)
	Bob Worden	Midnapore (Term completed Oct. 1987)

The office of the Committee is on the second floor of the Pacific Plaza, 10909 Jasper Avenue, Edmonton, T5J 3M9. Telephone 427-4924.

Executive Assistant:	Amelia Griffin	Edmonton
Secretary:	Margaret Dalton	Edmonton

Alberta
HEALTH FACILITIES REVIEW COMMITTEE

2nd Floor, Pacific Plaza, 10909 Jasper Avenue, Edmonton, Alberta, Canada T5J 3M9 403/427-4924

1 March 1988

The Honourable Marvin Moore,
Minister of Hospitals and Medical Care,
Room 423, Legislature Building,
EDMONTON, Alberta.

Dear Mr. Moore:

I have the honour to present the Annual Report of the Alberta Health Facilities Review Committee, summarizing the activities of the Committee for the year ending 31 December 1987.

Respectfully submitted,

Alan W. Hyland

Alan W. Hyland, M.L.A.
Chairman

1987
ANNUAL REPORT

of

THE ALBERTA HEALTH FACILITIES REVIEW COMMITTEE

Submitted to

THE HONOURABLE MARVIN MOORE
Minister of Hospitals and Medical Care

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MISSION STATEMENT

The mission of the Alberta Health Facilities Review Committee is to ensure that quality care, treatment and standards of accomodation are maintained in health care facilities and lodges across Alberta.

The Committee will provide the people of Alberta with a group of citizens to whom they may address their concerns relating to the care, treatment and standards of accomodation at a health care facility or lodge in the province.

The Health Facilities Review Committee acknowledges the importance of preserving the dignity and confidentiality of those individuals within the facilities the Committee visits.

The resources of the Committee are dedicated to ensuring that these values prevail in the delivery of care across the province of Alberta.

ALBERTA HEALTH FACILITIES REVIEW COMMITTEE

The Alberta Health Facilities Review Committee is made up of twelve citizens from various centres in the Province. Members are appointed by Ministerial Order for terms ranging from one to three years, and are of varying ages and backgrounds. All members serve on the Committee on a part time basis, and are not employees of the Government.

The Committee has a mandate from the Provincial Government to visit health care facilities throughout the Province for the purpose of reviewing and inspecting them, and observing the manner in which they are operated. Institutions included are General Hospitals, Auxiliary Hospitals, Nursing Homes, Mental Health Facilities, and Senior Citizens Lodges. Included in the mandate is the responsibility for receiving and investigating complaints about health care facilities.

All health care facilities are visited by Committee members on a regular basis. Visits to institutions are unannounced. They are planned monthly and are authorized by resolution of the Committee.

The visiting team reports on such areas as care, atmosphere, comfort, food activities and programs, community involvement, patient morale, staff morale and general attitudes, and physical facilities. Members prefer to conduct the visit unaccompanied by staff members of the facility and particular attention is given to discussion with patients and staff on a one-to-one basis. The Committee sees its role as that of considering the institution from a patient's or resident's point of view. For example: Does this hospital provide the kind of care I would look for if I were sick? Is this a hospital where I would confidently bring my sick child? Does this nursing home provide the comfort I would wish for my parent? All comments are brought to the attention of the administration.

Complaints take precedence over routine visits, and are investigated as soon as possible. Members authorized to do so by resolution of the Committee investigate each complaint thoroughly and make a full report. If regulations have been violated, or if a complaint on another matter is justified, it is brought to the attention of the administration and the Board of the institution with recommendations for the correction of the problem. The Committee has found Boards and administration responsive to making corrections where necessary, but if the recommendations of the Committee are ignored, or not put into effect within a reasonable period of time, the matter is referred to the Minister of Hospitals and Medical Care.

People having concerns are encouraged to discuss them with the nursing supervisor, administrator, trustees or other officials of the facility, then, if they are still not satisfied that the problem has been resolved, to write to the Committee.

All complaints are handled confidentially.

ACKNOWLEDGEMENTS

During the year, the terms of appointment of four members ended, and the Committee was sorry to lose their experience and knowledge of health care facilities in Alberta. Members wish to express their sincere appreciation to Mr. Ed Andersen, Mrs. Betty Biddell, Mr. Brian Elliott and Mr. Bob worden for their valuable contribution to the work of the Committee.

Mrs. Dianne Mirosh, M.L.A., also left the Committee when she was appointed to chair the Committee on Long Term Care for Senior Citizens, and members wish to thank Mrs. Mirosh sincerely for her contribution.

ACTIVITIES - 1987

In executing the Committee's mandate in 1987, members made routine unannounced visits to health care facilities and senior citizens' lodges, received and investigated complaints and made recommendations to the Minister of Hospitals and Medical Care, the Minister Responsible for Housing and to local Boards.

In January, members of the Committee met for a two-day retreat. Under the direction of the Minister of Hospitals and Medical Care, the Committee reviewed its mandate and the operations required to carry it out. As a result, the Committee documented its mission statement and compiled an extensive reference manual on its operations.

DISCUSSIONS WERE HELD WITH THE FOLLOWING:

The Honourable Marvin Moore,
Minister of Hospitals and Medical Care

Honourable Ken Rostad,
Solicitor General and Minister Responsible for Housing

Dr. Alex Mcpherson,
Deputy Minister,
Department of Hospitals and Medical Care

Dr. Allen Murdock,
Assistant Deputy Minister,
Home Care, Public Health Division

Ms. Irene McDermott,
Project Manager,
Reserach and Strategic Planning Branch,
Hospitals and Medical Care

Ms. Sheila Weatherill,
Long Term Planner, Home Care Unit
Community and Occupational Health

Senior Citizens' Secretariat

CONVENTIONS ATTENDED:

Senior Citizens Homes Association Convention

Alberta Hospital Association Convention

Rural Health Care Association of Alberta's Third Conference

SEMINARS ATTENDED.

Forum on Geriatic Care

People and Progress: Exploring the Future in Long Term Care

Aging with Excellence

Information Session on Single Point of entry and Alberta Assessment/Placement Instrument.

INTRODUCTION

The emphasis in seminars, conventions and workshops in 1987 was on planning for the future. Recent predictions have shown that, by the year 2030, 18% of the North American population will be 65 years or over. It seems appropriate, therefore, for the purposes of this report, to focus on the needs in long term care.

LONG TERM CARE

In 1982, the report and recommendations of the Alberta Nursing Homes Review Panel, also known as the Hyde Report, was released. Since that time members of the Health Facilities Review Committee have noted a significant change in long term care facilities. The nursing staff has increased; physical, occupational and recreational therapists are now a vital part of a multidisciplinary team that includes a physician, a dietician and a pharmacist; families are included in conferences that help plan the care of their family member.

Committee members have also been impressed with the fact that many lodges have a part-time or full-time recreational co-ordinator, and the residents of these facilities benefit from the opportunity to participate in a variety of activities and programs.

There are at present pilot projects underway in the Calgary and Foothills Health Units on single point of entry, assessment and placement. Also, a patient classification tool is being developed by the Department of Hospitals and Medical Care.

In April 1987, the Honourable Marvin Moore, Minister of Hospitals and Medical Care, established a committee on long term care for seniors, and appointed Mrs. Dianne Mirosh, M.L.A. as chairperson. This committee is to review and make recommendations to the Minister on long term care for seniors into the 21st century. The committee invited input from a number of organizations, including the Health Facilities Review Committee. A subcommittee was formed and met with the Long Term Care Committee in August 1987 and subsequently submitted a preliminary report on the Health facilities Review Committee's findings over the years and its views on changing trends in lodges, nursing homes, auxiliary and active treatment hospitals.

The Committee was also asked to continue its survey regarding the accommodation preferences of Alberta's senior citizens and their perception of the single point of entry system in areas where the pilot projects are being carried out.

In the Health Facilities Review Committee's preliminary report to the Long Term Care Committee, recommendations were made to:

1. Restructure Home Care to provide sufficient care and assistance to allow senior citizens to remain in their homes for as long as possible.

2. Train staff of senior citizen's lodges.

3. Emphasize rehabilitation programs for long term care patients, particularly for those remaining for extended periods in active treatment hospitals.

4. Consider multi-level care projects in future development. (Self-contained units, lodge, nursing home and auxiliary hospital.)

5. Establish one Department of Government charged with the responsibility of providing all health and housing requirements for Alberta's senior citizens.

6. Support single point of entry system in which senior citizens lodges are included. Gather information on how the client group perceives the single point of entry system in pilot areas.

7. Encourage Home Care nurses to do medication reviews when visiting clients in their provate homes and lodges.

Preliminary results from the survey on psychogeriatic care were included.

The Health Facilities Review Committee will continue to monitor these areas, and will forward its final report and recommendations to the Long Term Care Committee in the spring of 1988.

COGNITIVELY IMPAIRED RESIDENTS - A SURVEY

On visits to nursing homes and auxiliary hospitals, Committee members noticed that a significant number of residents appeared to be cognitively impaired or suffering from some form of dementia resulting in unpredictable behaviour. In some instances staff expressed concern about the residents' management.

The Committee undertook an informal survey in July 1987 to assess the situation, and questionaires were sent to auxiliary hospitals and nursing homes.

RESPONSE

Out of 126 facilities 94 submitted responses to the survey. Most facilities responded to each question although some institutions gave only partial replies. Many did not interpret the survey as applying only to aggressive or violent patients. Because of the significant differences in approach to answering the two questions listed below no attempt was made to quantify these responses.

How is the staff distributed over a 24 hour period?

How many staff are qualified to manage an aggresive or violent patient?

Summary results, by survey question, are presented below.

OF THE TOTAL RESIDENT POPULATION IN THE SAMPLE, (1) HOW MANY ARE COGNITIVELY IMPAIRED AND (2) HOW MANY HAVE BEHAVIORAL PROBLEMS?

Of the 94 surveys received, 92 completely answered questions 1 and 2. Some facilities reported both in-patient and out-patient information, however, only the in-patient portion was included in this analysis. For those facilities which answered the questions in ranges, the mid point of the range was used in these calculations (eg. 10 residents were used if the facility said 8-12 residents were cognitively impaired).

Total residents of the 92 facilities numbered 7,601. Of these, 3057 (40.2%) were reported as being cognitively impaired. Most facilities did not distinguish between Alzheimers patients and those with other forms of dementia or behavioural disorders.

There were 1,612 (21.2%) residents described as unpredictable, 1,002 (13.2%) as aggressive and 315 (4.1%) as violent. A number of facilities expressed concerns that no definitive statements were provided to describe "cognitively impaired", "unpredictable", "aggressive" and "violent".

HOW OFTEN ARE MEDICATIONS REVIEWED?

All 94 facilities submitted a response to this question. Medications are reviewed by a number of personnel at various times throughout the year. Most facilities did not specify who was primarily responsible for the reviews (i.e. physicians, nurses or pharmacists). Regarding the frequency of review, data were grouped into three categories: 4 weeks or less, 5 to 12 weeks and 13-24 weeks.

Of the 94 reporting facilities, one gave no time frame for medication review ("as required" was the complete response). Although most of the remaining 93 specified that reviews were done "upon request" and "as necessary", they all provided some time frame(s): 46 (49.5%) facilities reported that medications were reviewed at least once within a four week period; 83 facilities (89.2% reported reviews at least once within a 5 to 12 week period and all 93 facilities (100.0%) reported reviews at least once every six months.

Of all reviews reported within a 4 week period, 20.3% were said to be carried out by physicians, 10.2% by nurses, 8.5% by pharmacists and 61.0% either did not state who was responsible for the review or stated some other source.

Considering only those facilities reporting reviews within a 3 month period, 18.3% of all reviews were carried out by physicians, 7.3% by nurses, 6.4% by pharmacists and 67.9% did not report who did the review or stated another source.

Finally, of all reviews done over a 6 month period, 17.6% were reported carried out by physicians, 6.4% by nurses, 8.0% by pharmacists and 68.0% did not specify who did the reviews or listed another source.

A brief table has been completed to summarize these results.

*REVIEW OF MEDICATIONS
LONG TERM CARE SURVEY RESULTS

Frequency of Review	Number of Facilities	Responsibility For Review			
		Physicians %	Nurses %	Pharmacists %	Unspecified ** %
4 weeks or less	46	20.3	10.2	8.5	61.0
5 to 12 weeks	83	18.3	7.3	6.4	67.9
13 - 24 weeks	93***	17.6	6.4	8.0	68.0

*It is not clear whether responses to this question on the survey refer only to aggressive or violent residents or if they refer to all residents.

**A Number of facilities did not specify who was responsible for reviews at the various points in time throughout the year.

***All 93 facilities (100.0%) reported reviews at least once every six months.

DO YOU USE RESTRAINTS?

All 94 facilities responded to this part of the survey. Although the question was meant to refer to use of restraints on aggressive or violent residents, most facilities did not answer from this perspective. Of the 94 facilities, 12 (12.8%) stated that no restraints were used at all. Most of the remaining 82 facilities expressed that the use of restraints was primarily for safety precautions (eg. to prevent residents from falling out of chairs, beds and so forth). A number of institutions discussed preventative measures which have enabled them to minimize violent outbreaks to some degree and therefore minimize the need for restraints. Generally, however, facilities are not using restraints to control violent residents unless ordered by a physician.

A list of restraints included in each category follows the summary table for this question. The three types of restraints reported most often were: lower body/trunk, reported by 63.8% of all surveyed facilities; upper body, reported by 41.5% and special chairs, reported by 30.9%.

USE OF RESTRAINTS BY TYPE OF RESTRAINT
LONG TERM CARE SURVEY RESULTS*

	None	Lower Body	Upper Body	Limbs	Posture Support	Special Chairs	Bed Restraints	Half Doors	Medications	Other
Number of Survey Respondents	12	60	39	7	3	29	12	5	9	12
Percent ** of Total Respondents (%)	12.8	63.8	41.5	7.4	3.2	30.9	12.8	5.3	9.6	12.8

* Restraints are used primarily for safety percautions and not to control violent behavior.

** Percentages are based on the total 94 facilities which responded to this part of the survey.

TYPES OF RESTRAINTS

Lower Body/Trunk
- hip/lap belts or ties, posey safety belts, commode chair belts, body belts, toilet belts, wheel chairbelts

Upper Body
- Posey shoulder harness, posey vest, waist coat restraints

Limbs
- knee and ankle ties, arm and wrist ties, gloves, mittens

Posture Support
- foam chest support, posey corex posture support

Special chairs
- geriatric or cardiac chairs with overtables, roll posey, tray tables

Bed Restraints
- bed side rails, key lock beds

Medications
- chemical restraints

WHAT TYPE OF IN-SERVICE TRAINING DO YOU HAVE TO ADDRESS THE PROBLEM OF DEALING WITH AGGRESSIVE OR VIOLENT RESIDENTS?

All 94 facilities responded to this survey question. The responses were grouped into seven categories which are listed below. There were 17 (18.1%) facilities which reported having no (or few) training programs to address the problem of dealing with aggressive or violent residents. Although all other 77 facilities reported having at least one program, many expressed concerns that staff training was inadequate. Some facilities commented that they had insufficient funds to arrange such programs while others reported that their facility was not designed for (and rarely has) violent patients and staff training did not focus on this issue. Still others reported that there was inadequate community support groups to help in providing appropriate training sessions for the institutional staff.

Many facilities reported combinations of the types of programs listed below. Although only 45 out of 94 facilities mentioned that staff learn through on-the-job training with a supervisor, it is likely that this category applies, in various degrees, to all the institutions.

TYPES OF TRAINING PROGRAMS

1. None or few
2. Printed literature, audio-visual material, teleconferencing
3. Workshops, sessions and courses
4. RCMP or Police workshops (emphasis on self-defence)
5. Guest Speakers - Qualified Professionals
6. On-the-job training with supervisor
7. Other

The reponses to this question were quite general making it difficult to make definitive statements concerning the relationship between the type of training and facility location. Sampling and "small number" problems may also exist (ie. Do we have a representative sample for each location and do we have a sufficient number of facilities in each location to make the results meaningful?). A third problem relates to the amount of detail provided in the survey. Some facilities offered short replies while others fully explained all their programs.

Based on what was recorded, there does not appear to be significant differences in the types of training programs offered in Calgary and Edmonton long term care facilities (especially considering that the categories #5 (Guest Speakers) and #3 (Workshops) likely overlap). Facilities outside of Edmonton and Calgary seem to offer fewer training programs overall and tend to rely more on RCMP and local police for training assistance than do the Edmonton and Calgary institutions.

IN-SERVICE TRAINING BY TYPE OF PROGRAM AND LOCATION OF FACILITY, LONG-TERM CARE SURVEY RESULTS

Type of Training Program

Location of Facility		None or Few	Printed Lit. Audio Visual Teleconferencing	Workshops Sessions or Courses	RCMP or Policy Workshops	Guest Speakers	On-the-job Training	Other
CALGARY (13 Surveyed Facilities)	Number of Responses	1	6	10	0	3	10	0
	Percentage of Calgary (%)	7.7	46.2	76.9	0	23.1	76.9	0
EDMONTON (15 Surveyed Facilities)	Number of Responses	0	6	7	0	8	10	0
	Percent of Edmonton (%)	0	40.0	46.7	0	53.3	66.7	0
OTHER (66 surveyed Facilities)	Number of Responses	16	23	30	3	17	25	1
	Percent of Other (%)	24.2	34.8	45.5	4.5	25.8	37.9	1.5
TOTAL (94 Surveyed Facilities)	Number of Responses	17	35	47	3	28	45	1
	Percent of Total (%)	18.1	37.2	50.0	3.2	29.8	47.9	1.1

WHAT IS YOUR EMERGENCY POLICY IN IN DEALING WITH A VIOLENT PATIENT?

Of the 94 facilities which responded to this question, 11 (11.7%) stated that they had no formal policy. Another 14 (14.9%) reported having no formal policy but went on to explain what actions would be taken if a violent outbreak occurred. The remaining 69 facilities (73.4%) did not make reference to whether there was a formal policy for dealing with a sudden violent outbreak but did list the actions they might take should the situation arise.

The responses of the 94 facilities were grouped into 9 categories as follows:

1. No formal policy (no other answer given)
2. Transfer to active hospital
3. Transfer to mental health hospital (given sufficient time)
4. Call for medical assistance (physician, psychiatrist)
5. Call for security (RCMP or Police)
6. Restrain (primarily isolation)
7. Medicate
8. Have preventative policies to avoid sudden violent outbreaks
9. Other

The table below summarises the information obtained from this survey question.

POSSIBLE EMERGENCY ACTIONS TAKEN WHEN DEALING WITH VIOLENT RESIDENTS LONG TERM CARE SURVEY RESULTS

Potential Actions

	No Formal Policy	Transfered Active	Transfered Mental Health	Call Physician/ Psychiatrist	Call Security	Restraints Imposed	Medications	Preventative Policies	Other
Number of Survey Responses	11	24	18	58	29	28	25	25	46
Percent of * Total Facilities Surveyed (%)	11.7	25.5	19.1	61.7	30.9	29.8	26.6	26.6	48.9

*Percentages based on total 94 facilities which responded to the survey.

IS THE STAFF FAMILIAR WITH THE SUPPORT SERVICES IN THE COMMUNITY?

All 94 facilities responded to this question. Of the 94 facilities, 83 (88.3%) reported that the staff was aware of the community support services, 5 facilities (5.3%) reported that the majority of the staff were not fully aware of all support programs and 6 facilities (6.4%) responded that the staff was somewhat aware of community support services but these services, for the most part, are too few in number or inappropriate for the facilities needs.

ACKNOWLEDGEMENT

The Committee wishes to thank the facilities that took the time to respond to the questionaire, and a special thanks to Dr. Y.M. Cheung and the Department of Health Economics and Statistics, Alberta Hospitals and Medical Care, for their assistance in compiling the results.

WESLEY HALL - AN EXPERIMENT

It is estimated that at present there are approximately 400,000 Canadians suffering from dementing illnesses such as Alzheimer's disease. Victims of these brain diseases gradually lose their memories and their ability to speak coherently, do simple tasks, manage their self care, or control their own behavior.

A two year research study, the Wesley Hall Experiment, was undertaken in 1983 by the Institute of Gerontology of the University of Michigan and the Chelsey United Methodist Retirement Home. The program involved establishing a dementia unit for a total of eleven residents (9 women and 2 men). The residents ranged in age from 67 to 90. They were bordering on severely impaired but were ambulatory, able to feed themselves, and required only minimum medical care. They were neither phycically nor chemically restrained. The residents could manage their self care with some assistance, and could follow simple instructions. One of the eleven had a diagnosis of dementia secondary to viral encephalitis. Of the remaining residents, the physicians' presumed diagnosis were Alzheimers disease or multi-infract dementia.

The following criteria were considered important in the design of the unit:

a) Because of individual differences, a program for dementia requires variety and constant change.
b) Staff have to be trained and truly committed.
c) There have to be new medical programs.
d) Regular assessment is essential.
e) Evaluation of medical condition is important.
f) Familiarity and congruity are important.
g) Integration versus separation is important.

The pilot project resulted in a unique living situation which created a high quality of life for a population that is often considered untreatable.

The Chelsey United Methodist Retirement Home in Chelsey, Michigan, includes senior citizens' apartments, a large retirement home and a nursing home area. One section of the retirement home was converted into a small, intimate and easily manageable area and named Wesley Hall. Its homelike environment included a small kitchen, a cozy den, an attractive dining area and a living room. Wesley Hall was unlocked, and the environment was bright and stimulating, with colour contrast to compensate for sensory loss. All rooms were private and residents were integrated irrespective of their functioning level. The environment was also "orienting". For example, there were canopies over the bathroom doors for easy recognition, and some doors were camouflaged to avoid residents going through them.

There was no nursing station in the unit. Instead, there was a table in the kitchen for staff to do paperwork and a desk in the dining-room for administration purposes. Tactile and visual stimulation was encouraged with the use of pictures, flags, maps, family photographs and letters, and personal items from the resident's earlier life.

Residents had access to all areas and safety designed equipment, such as coffee urns and refrigerators for snacks or juice. Communication between staff and residents was direct and the use of intecom was avoided. Residents had flexible bath and meal times and were encouraged to perform simple household chores such as helping with washing, cooking, and cleaning.

Staff did not wear uniforms and behaved like peers rather than teachers. They responded to the special needs, moods and capacities of residents. They recognized the importance of helping the residents to succeed by using the technique of breaking down tasks into a series of steps and giving instructions in a simple, repetitive way. Staff had a relaxed undemanding approach, and residents were given choices rather than orders. Humour, acceptance, affection, patience and touch played major roles in establishing the climate and tone of the area. Staffing included one full-time co-ordinator, one full-time and one half-time resident aide on day and afternoon shift, and a part-time resident assistant on the night shift, and a part-time housekeeper. Medications and other medical care were administered by the nursing staff from the Retirement Home. The primary physician, who was the Medical Director of the Home, examined each resident at the time of admission, consulted weekly with staff, and prescribed medical treatment.

Changes that evolved included the following:

1) Personal appearance gradually improved. Residents who had looked ill, confused and bewildered before coming to the area, and who had seemed out of touch and sometimes angry or depressed, improved. They became more alert, well looking and involved to the extent that their impairment was not obvious to visitors. Residents smiled more readily and were quick to establish eye contact with people approaching them.

2) Four of the eleven residents who were considered to be incontinent had decidedly improved. An individualized toileting schedule and intervention plan was implemented for each resident. This, together with a definite increase in the intake of liquid, helped to reduce their incontinence.

3) There was a reduction in night wanderings and evening agitation. Most residents were described by staff as being both night and day wanderers when they were in the Retirement Home. For several months, nights were as active as days. The period after the evening meal was the most difficult to ressolve, and a number of interventions were tested. One of the most effective was the introduction of a variety of activities involving most of the residents. Gradually this period became the most active time of the day. Residents became involved to the point that most went to bed at 10:00 p.m. or 11:00 p.m. tired and diverted from the problems that seem to cause them so much stress.

The award winning video tape documentary of Wesley Hall is available at the Long Term Care In-Service Resource Centre, Southern Region, 1070 McDougall Road N.E., Calgary, T2E 7Z2,
Telephone No: 267-2910 (Local) or 237-5288 (Long Distance).- Reverse Charges)

ACKNOWLEDGEMENT:

Dr. Shelley Weaverdyck, Ph.D.
(Speaker)
Psychology Department,
University of Michigan.

Dorothy H. Coons,
Director, Alzheimer's Disease Projects,
University of Michigan.

PALLIATIVE CARE

The word "palliative" means "having a relieving or soothing, but not curative, action". Where there is no longer a possibility of cure, palliative care provided by trained personnel allows a patient to die with dignity in a supportive environment. It has been noted that there are now more formalized programs on palliative care, but there still seems to be a need, particularly in rural areas, for additional programs.

There are resources, and personnel trained in this area that could be utilized to further enhance the staff's experience in this special field. The marked increase in AIDS cases will mean a further demand on palliative care, as it has been suggested that 70% of AIDS patients may die within two years of diagnosis.

As an increase in demand will require a corresponding increase in personnel, more in-service training in palliative care is required in health care facilities, and also for Home Care staff caring for patients who prefer to remain in their homes. The Health Facilities Review Committee recommends a significant increase in special training to meet this need.

ACTIVE TREATMENT HOSPITALS

Continuing the focus of this report on long term care, there is still a concern regarding the number of long term care patients in active treatment hospitals. The active treatment hospital and its staff are not specialized in looking after Long Term Care patients, or providing the activities and programs necessary for their rehabilitation. With new auxiliary beds planned for the future, there is hope that this problem will be resolved.

A number of positive programs have been incorporated in active treatment hospitals. Hospitals are seeing a definite need for pastoral and palliative care, and Ministerial Associations in communities offer their services to facilities which do not have fulltime pastoral care.

SENIOR CITIZENS LODGES

Senior Citizens' Lodges are increasingly making use of the services of Home Care Personnel in preparing medications for those residents requiring such assistance. A valuable side benefit is that, as Home Care staff are frequent visitors, they are available to discuss health concerns with residents.

A number of Resident Supervisors have completed the "Educational Program for Managers of Senior Citizen Facilities" and are enthusiastic about the information they have received. Many have expressed an interest in following up with a more advanced course. Also, dietary staff are making use of the help available from dieticians in the community.

Committee members have noted that a number of lodges now have either a staff member or a volunteer responsible for planning and organizing recreational activities. Having a Recreational Coordinator on staff seems to result in increased participation which enhances the quality of life of the residents.

COMPLAINTS

An important part of the Committee's mandate is to be available to people having concerns about the care provided in health care facilities, or about the services provided in lodges.

When a complaint is received, members are appointed to investigate. Wherever possible, they interview the complainant before visiting the facility unannounced. Concerns are then discussed with the administration and the staff involved. Depending on the nature of the complaint, the investigation can take a number of days or weeks.

Some complaints arise from misunderstandings or lack of communication, and, in those cases, the Committee has found it helpful to arrange a meeting between the appropriate people from the facility and the complainant, with the investigating members acting as facilitators. Committee members recognize the need for confidentiality.

Two examples of complaints received in 1987 follow:

The following case summaries, one from a nursing home and one from an acute care hospital, are examples of problems arising out of lack of communication between the parties involved.

Case number one:

The Committee received concerns from a family member of a former resident of a nursing home. Although the resident had been transferred to another facility, the family member believed that some aspects of the care provided in the nursing home required investigation.

The complainant stated that changes in the resident's condition were not being reported to the family. He also stated that the meal service was poor and the resident was losing weight. The complainant was visiting regularly at meal times, and had observed that the residents's appetite was declining. He had passed on these observations to the staff, but felt that his comments were not being taken into account in the care of his relative.

An unannounced visit was made to the facility and the concerns were discussed with administration and staff from Nursing and Dietary Departments. Many residents and family members were interviewed to gain their impressions of the care being provided. With the consent of the complainant, the resident's medical records were examined.

A review of the meal service included examining menus and procedures for serving meals. Committee members also had a meal at the nursing home.

Observations made during the investigation revealed that staff were generally well acquainted with the condition and needs of the resident. However, it was recommended that formal procedures be followed to notify family members of a resident's condition, and suggestions were made to improve the meal service and to monitor resident's eating habits.

Recommendations:

1. Multi-disciplinary care planning should be conducted within a month of admission. Afterwards, team conferences should be scheduled regularly. These conferences should include, whenever possible, the family and the resident.
2. Written material should be prepared and distributed to families and residents to provide general information about the facility.
3. A Residents Council should be established with a staff member acting as liaison with the group to facilitate the exchange of information and/or concerns.
4. Residents' satisfaction should be monitored by distributing a questionaire.
5. Charting should be reviewed to ensure that observations made by nursing aides are noted by registered nurses.
6. The menu should be followed as posted. Any changes made when meals were prepared should be recorded.
7. A daily menu should be posted for the residents' information.
8. The dietician should consult with the resident whenever a loss of appetite of loss of weight were noted.
9. Residents should be weighed regularly.
10. Temperature of foods, and the amount of food not eaten, should be monitored regularly.

Case number two:

A complainant's husband had been diagnosed as terminally ill, and he was in and out of various hospitals for an extended period of time. Following a brief stay at home, the patient was admitted to an active treatment hospital where he died three days later.

There were two concerns. One, the complainant was informed at the time of admission that she could visit her husband only during scheduled visiting hours, from noon until 8:00 P.M.; and, two, the complainant was not contacted directly when her husband's condition began to deteriorate.

As a result of the complainant's distress with the visiting restrictions, she requested that her husband be transferred to another facility, and elected not to visit her husband until such arrangements could be made. Unfortunately, her husband passed away before she visited again.

The Committee met with the family of the deceased. Areas which required investigation included clarification of policies on visiting hours, and exceptions to normal visiting hours in the case of terminally ill patients. Procedures for notification of next of kin when changes are noted in a patient's condition were also investigated. With the consent of the complainant the deceased's medical records were examined and members convened a meeting with the personnel at the hospital.

It was determined that the facility had not intentionally denied the complainant access to her husband, and did not realize that the request for a patient transfer was also an indication that she would not visit the facility again. When the patient's condition worsened it was assumed that other family members who had visited would adequately inform the patient's wife of the circumstances.

It was regrettable that a series of misunderstandings occurred between the family and the facility. The actions taken later by the facility to address the complainant's concerns were sensitive to the difficulties experienced, and they will be effective in preventing similar occurrences.

Although a policy to allow extended visiting privileges for families of terminally ill patients was in place, this was re-examined and revised to allow for greater flexibility. The facility will maintain its practice of clearly displaying its policies on visiting privileges. Reporting mechanisms when there is a change observed in a patient's condition were also re-examined and clarified.

In a letter expressing regret for the distress caused by the situation, the hospital's revised policies were forwarded to the complainant. The facility also addressed the need for palliative care, and invited the complainant to provide input into its review of its Compassionate Care Support Committee.

This case highlights the difficulties and distress which may result when effective communication does not exist between the Parties involved.

DID YOU KNOW

Long Term Care Inservice Resource Centres are designed to meet inservice needs of staff working in long term care. They provide videos, books, periodicals and other training and educational material.

Northern Region,
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CALGARY, Alberta.
T2E 7Z2

Telephone No:
(403) 267-2910 (local calls)
(403) 237-5288 (Long Distance - Reverse Charges)

Of the following facilities, 89 acute care hospitals, 27 auxiliary hospitals, 59 nursing homes, 99 senior citizens lodges and one mental health hospital were visited in 1987.

HOSPITALS

ATHABASCA, Athabasca Municipal
BANFF, Mineral Springs
BARRHEAD, Barrhead General
BASHAW, Bashaw General
BASSANO, Bassano General
BEAVERLODGE, Beaverlodge Municipal
BENTLEY, Bentley General
BLACK DIAMOND, Oilfields General
BLAIRMORE, Crowsnest Pass General
BONNYVILLE, St. Louis & Health Centre
BOW ISLAND, Bow Island Health Care Centre
BOYLE, Boyle General
BRETON, Breton General
BROOKS, Brooks Health Centre
CALGARY, Alberta Children's Provincial General
CALGARY, Calgary General
CALGARY, Colonel Belcher
CALGARY, Foothills Provincial General
CALGARY, Holy Cross
CALGARY, Rockyview General
CALGARY, Salvation Army Grace
CALGARY, Tom Baker Cancer Centre
CAMROSE, St. Mary's
CANMORE, Canmore Municipal
CARDSTON, Cardston Municipal
CASTOR, Our Lady of the Rosary
CEREAL, Cereal Municipal
CLARESHOLM, Claresholm General
COALDALE, Coaldale Community
COLD LAKE, Cold Lake Regional
CONSORT, Consort Municipal
CORONATION, Coronation Municipal
DAYSLAND, Daysland General
DEVON, Devon Civic
DIDSBURY, Mountain View Health Care Centre
DRAYTON VALLEY, Health Care Complex
DRUMHELLER, Drumheller Regional Health Complex
ECKVILLE, Eckville Municipal
EDMONTON, Alberta Hospital
EDMONTON, Charles Camsell
EDMONTON, Edmonton General
EDMONTON, Glenrose Provincial General
EDMONTON, Misericordia
EDMONTON, Royal Alexandra
EDMONTON, University of Alberta
EDMONTON, W.W. Cross Cancer Institute
EDSON St. John's Health Care Complex
ELKPOINT, Elk Point Municipal
ELNORA, Elnora General
EMPRESS, Empress Municipal
FAIRVIEW, Fairview General
FORT MACLEOD, Health Care Centre & Special Development Unit
FORT MCMURRAY, Fort McMurray Regional
FORT SASKATCHEWAN, Fort Saskatchewan General
FORT VERMILION, St. Theresa General
FOX CREEK, Fox Creek
GALAHAD, Galahad General
GLENDON, Glendon Municipal
GRANDE CACHE, Grande Cache General
GRANDE PRAIRIE, Queen Elizabeth II
GRIMSHAW, Grimshaw/Berwyn & District
HANNA, Hanna General
HARDISTY, Hardisty General
HIGH LEVEL, High Level Community Health Centre
HIGH PRAIRIE, High Prairie Regional Health Complex
HIGH RIVER, High River General
HINTON, Hinton General
HYTHE, Hythe Municipal
INNISFAIL, Innisfail Health Care Centre
ISLAY, Islay Municipal
JASPER, Selon General
KILLAM, Killam General
LAC LA BICHE, William Cadzow General Hospital
LACOMBE, Lacombe General
LAMONT, Archer Memorial
LEDUC, Leduc Municipal
LETHBRIDGE, Lethbridge Regional
LETHBRIDGE, St. Michael's General
MAGRATH, Magrath Municipal

MANNING, Manning Municipal
MANVILLE, Manville Municipal
MAYERTHORPE, Mayerthorpe General
MCLENNAN, Sacred Heart
MEDICINE HAT, Medicine Hat and District (General Centre)
MILK RIVER, Border Counties General
MUNDARE, Mary Immaculate General
MYRNAM, Myrnam Municipal
OLDS, Olds Municipal
OYEN, Big Country General
PEACE RIVER, Peace River Municipal
PICTURE BUTTE, Picture Butte Municipal
PINCHER CREEK, Pincher Creek Health Care Centre
PONOKA, Alberta Hospital
PONOKA, Ponoka General
PROVOST, Provost Municipal (Health Care Centre)
RAYMOND, Raymond Municipal
RED DEER, Red Deer Regional
REDWATER, Thorhild County General
RIMBEY, Rimbey General
ROCKY MOUNTAIN HOUSE, Rocky Mountain House General
SLAVE LAKE, Slave Lake General
SMOKY LAKE, George McDougall Memorial
SPIRIT RIVER, Central Peace General
STETTLER, Stettler General
STONY PLAIN, Stony Plain Municipal
STRATHMORE, Valley General Hospital
ST. ALBERT, Sturgeon General
ST. PAUL, St. Therese General
SUNDRE, Sundre General
SWAN HILLS
TABER, Taber General & Health Care Complex
THREE HILLS, Three Hills Municipal
TOFIELD, Tofield Municipal
TROCHU, St. Mary's Health Care Centre
TWO HILLS, Two Hills Health Care Centre
VALLEYVIEW, Valleyview Health Centre
VEGREVILLE, St. Joseph's General
VERMILION, Vermilion Health Care Complex
VIKING, Viking General
VILNA, Our Lady's General
VULCAN, Vulcan Municipal
WABASCA/DESMARAIS, St. Martin's Health Centre
WAINWRIGHT, Wainwright & Dist. Health Care Complex
WESTLOCK, Immaculate General
WETASKIWIN, Wetaskiwin General
WHITECOURT, Whitecourt General
WILLINGDON, Mary Immaculate General

AUXILIARY HOSPITALS

ATHABASCA, Athabasca
BARRHEAD, Dr. W.R. Keir Care Centre
BLACK DIAMOND, Oilfields Aux.
BOW ISLAND, Bow Island
BROOKS, Brooks
CALGARY, Bethany
CALGARY, Colonel Belcher
CALGARY, Crossbow
CALGARY, Dr. Vernon Fanning Extended Care
CALGARY, Foothills
CALGARY, Glenmore Park
CALGARY, Sarcee
CAMROSE, Bethany
CANMORE
CARMANGAY, Little Bow Municipal
CARDSTON, Cardston
CLARESHOLM, Willow Creek-Claresholm
COLD LAKE, Regional
CORONATION
DIDSBURY, Mountain View Health Care Centre
DRAYTON VALLEY
DRUMHELLER, Regional Health Complex
EDMONTON, Alberta Hospital
EDMONTON, Allen Grey
EDMONTON, Dickinsfield Extended Care Centre
EDMONTON, Good Samaritan
EDMONTON, Grandview
EDMONTON, Lynnwood
EDMONTON, Mewburn Veterans Centre
EDMONTON, Millwoods Shepherd's Care Centre
EDMONTON, Norwood
EDMONTON, St. Joseph's
EDMONTON, St. Michael's
EDMONTON, University of Alberta, (Aberhart Pavilion)
EDMONTON, Youville Geriatric Services
GRANDE PRAIRIE, Queen Elizabeth II
HIGH RIVER, High River
INNISFAIL, Innisfail Health Care Centre (Aux.)
ISLAY, Islay
KILLAM, Flagstaff
LAC LA BICHE, Lac La Biche (William Cadzow)
LACOMBE, Lacombe
LAMONT, Archer Memorial
LAMONT, Lamont
LETHBRIDGE, Lethbridge Regional (Rehab. Centre)
LLOYDMINSTER, Lloydminster
MANVILLE, Municipal
MEDICINE HAT, Medicine Hat & District (Dr. McCharles)
MUNDARE, Mundare
OLDS, Municipal
OYEN
PONOKA, Alberta Hospital
PEACE RIVER, Peace River/Fairview
PINCHER CREEK, Pincher Creek
RADWAY, Radway Health Care Centre
RED DEER, Dr. Richard Parsons
RIMBEY, Rimbey
ROCKY MOUNTAIN HOUSE, Rocky Mountain House
SMOKY LAKE
STETTLER, Dr. A.E. Kennedy
TABER
THREE HILLS
TOFIELD, Municipal
TROCHU, St. Mary's
TURNER VALLEY
TWO HILLS, Health Care Centre
VEGREVILLE, (Minburn-Eagle)
VERMILLION, Health Care Complex
WAINWRIGHT, Wainwright & District Health Centre
WESTLOCK, Thorhild-Westlock
WETASKIWIN, Wetaskiwin
WHITELAW, Hotel Dieu Of St. Joseph

NURSING HOMES

ATHABASCA, Extendicare
BARRHEAD, Barrhead
BLAIRMORE, Crowsnest Pass
BONNYVILLE, Extendicare
BROOKS, Newell Health Centre
CALGARY, Bethany Care Centre
CALGARY, Beverly
CALGARY, Bow-Crest
CALGARY, Bow View
CALGARY, Brentwood
CALGARY, Cedars Villa
CALGARY, Central Park Lodge
CALGARY, Chinook
CALGARY, Extendicare
CALGARY, Forest Grove Care Centre
CALGARY, George Boyack
CALGARY, Glamorgan
CALGARY, Mayfair
CALGARY, Sarcee
CALGARY, Scottish
CALGARY, Southwood
CAMROSE, Bethany
CARDSTON, Grandview
CORONATION, Coronation-Paintearth
DIDSBURY, Mountain View Health Care Centre
DRAYTON VALLEY
DRUMHELLER, Regional Health Complex
EDMONTON, Central Park Lodge
EDMONTON, Dickinsfield Extended Care Centre
EDMONTON, Dr. Angus McGugan Pavillion (Norwood)
EDMONTON, Extendicare North
EDMONTON, Extendicare Southgate
EDMONTON, Good Samaritan Mount Pleasant
EDMONTON, Good Samaritan Southgate
EDMONTON, Hardisty
EDMONTON, Jasper Place Central Park Lodge
EDMONTON, Jubilee Lodge
EDMONTON, Millwoods Shepherds Care Centre
EDMONTON, St. Michael's
EDMONTON, Venta
EDSON, Edson
FAIRVIEW, Fairview
FORT MACLEOD, Extendicare
FORT SASKATCHEWAN, Rivercrest Lodge
GRANDE PRAIRIE, Central Park Lodge
GRANDE PRAIRIE, Queen Elizabeth II
HANNA, Palliser
HIGH PRAIRIE, J.B. Wood
HIGH RIVER, High River
HYTHE, Hythe
LACOMBE, Lacombe
LAMONT, Lamont
LEDUC, Extendicare
LEDUC, Salem Manor
LETHBRIDGE, Edith Cavell
LETHBRIDGE, Extendicare
LETHBRIDGE, Southland
LINDEN, Linden
LLOYDMINSTER, Dr. Cooke
MAYERTHORPE, Extendicare
MCLENNAN, Our Lady of the Lake
MEDICINE HAT, Central Park Lodge
MEDICINE HAT, Sunnyside
MIDNAPORE, Father Lacombe
OLDS, Municipal
PEACE RIVER, Sutherland
PONOKA, Northcott Lodge
PROVOST, Provost Municipal Health Care Centre
RED DEER, Red Deer
RED DEER, Valley Park Manor
RED DEER, West Park
ST. ALBERT, Youville
ST. PAUL, Extendicare
SHERWOOD PARK, Sherwood Park
SMOKY LAKE, Smoky Lake
STETTLER, Stettler
STONY PLAIN, Good Samaritan
STRATHMORE
TABER
TOFIELD, Municipal
TROCHU, St. Marv's
TWO HILLS, Health Care Centre
VEGREVILLE, Vegreville
VERMILLION, Alice Keith Centre
VIKING, Extendicare
VULCAN, Extendicare
WESTLOCK, Westlock
WETASKIWIN, Wetaskiwin
LAC ST ANNE-Whitecourt District No. 27

SENIOR CITIZEN'S LODGES

ANDREW - Andrew Senior Citizen's Lodge
ATHABASCA - Pleasant Valley Lodge
BARRHEAD - Hillcrest Senior Citizens' Lodge
BASHAW - Bashaw Valley Lodge
BASSANO - Playfair Lodge
BERWYN - Autumn Lodge
BLACK DIAMOND - High Country Lodge
BLAIRMORE - York Creek Lodge
BONNYVILLE - Bonny Lodge
BOW ISLAND - Pleasant View Lodge
BOYLE - Wild Rose Villa
BROOKS - Newbrook Lodge
CALGARY - Beaver Dam Lodge #1200
CALGARY - Bow Valley Lodge #100
CALGARY - Bow Valley Lodge #200
CALGARY - Bow Valley Lodge#300
CALGARY - Bow Valley Lodge #1100
CALGARY - Confederation Park #1000
CALGARY - Elbow Valley Lodge #700
CALGARY - Elbow Valley Lodge #800
CALGARY - Jacques Lodge #400
CALGARY - Jacques Lodge #500
CALGARY - Jacques Lodge #600
CALGARY - James Shouldice Lodge #1300
CALGARY - Rundle Lodge #900
CALGARY - Valleyview Lodge #1400
CAMROSE - Stony Creek Lodge
CANMORE - Bow River Lodge
CARDSTON - Chinook Lodge
CASTOR - Painterth Lodge
CLARESHOLM - Porcupine Hills Lodge
COALDALE - Sunny South Lodge
COCHRANE - Big Hill Lodge
COLD LAKE - Cold Lake Senior Citizens' Lodge
CONSORT - Consort Senior Citizens' Lodge
CROSSFIELD - Rocky View Lodge
DRAYTON VALLEY - Shangri-La Lodge
DRUMHELLER - Sunshine Lodge
ECKVILLE - Eckville Manor House
EDMONTON - Belvedere Lodge
EDMONTON - Bethany Lodge
EDMONTON - Beverly Lodge
EDMONTON - Elmwood Lodge
EDMONTON - Kiwanis Place Lodge
EDMONTON - McCauley Lodge
EDMONTON - McQueen Lodge
EDMONTON - Meadowlark Lodge
EDMONTON - Northway Lodge
EDMONTON - Ottewell Lodge
EDMONTON - Pleasantview Place Lodge
EDMONTON - Queen Alexandra Lodge
EDMONTON - Rosslyn Lodge
EDMONTON - Virginia Park Lodge
EDSON - Parkland Senior Citizens' Lodge
ELK POINT - Heritage Lodge
EVANSBURG - Sunshine Lodge
FALHER - Villa Beausejour
FORESTBURG - Big Knife Comple Lodge
FORT CHIPEWYAN - Ayabashaw House
FORT MACLEOD - Pioneer Lodge
FORT SASKATCHEWAN - Dr. Turner Lodge
GIBBONS - Spruce View Manor
GRANDE PRAIRIE - Heritage Lodge
GRANDE PRAIRIE - Pioneer Lodge
GRANDE PRAIRIE - Wild Rose Manor
HANNA - Hanna Lodge
HIGH PRAIRIE - Pleasant View Lodge
HIGH RIVER - Medicine Tree Lodge
HINES CREEK - Homesteader Lodge
HOLDEN - Holden Lodge
HYTHE - Hythe Pioneer Home
INNISFAIL - Autumn Glen Lodge
LAC LA BICHE - Lacalta Lodge
LACOMBE - Lacombe Lodge
LAMONT - Beaverhill Pioneer Lodge
LEDUC - Planeview Lodge
LEGAL - Chateau Sturgeon Lodge
LETHBRIDGE - Alberta Rose Lodge
LETHBRIDGE - Blue Sky Lodge
LETHBRIDGE - Golden Acres Lodge
LETHBRIDGE - Green Acres Lodge
LETHBRIDGE - Heritage Lodge
LLOYDMINSTER - Pioneer Lodge
MAGRATH - Diamond Willow Terrace Lodge
MANNING - Del-Air Lodge
MAYERTHORPE - Pleasant View Lodge
MEDICINE HAT - Cypress View Lodge
MEDICINE HAT - Teeoda Lodge
MEDICINE HAT - Wild Rose Senior Citizens' Lodge
MILK RIVER - Prairie Rose Lodge
MORINVILLE - Heritage Place Lodge
MUNDARE - Father Filas Senior Citizens' Lodge
MYRNAM - Eagle View Lodge
NANTON - Silver Willow Lodge
OLDS - Mountview Lodge
OYEN - Prairie Home Lodge
PEACE RIVER - Heritage Tower
PICTURE BUTTE - Piyami Lodge
PINCHER CREEK - Crest View Lodge
PONOKA - Golden Leisure Lodge
PROVOST - Hillcrest Lodge
RAYMOND - Ridgeview Lodge
RED DEER - Pines Lodge
RED DEER - Piper Creek Lodge

REDWATER - Redwater Diamond Spring Lodge
RIMBEY - Parkland Manor
ROCKY MOUNTAIN HOUSE - Westview Lodge
SEDGEWICK - Flagstaff Lodge
SHERWOOD PARK - Sherwood Park Lodge
SMOKY LAKE - Bar-V-Nook Manor
SPIRIT RIVER - Pleasant View Lodge
ST. ALBERT - Chateau Mission Court
ST. PAUL - Sunnyside Manor
STETTLER - Heart Haven Home
STONY PLAIN - Meridian Lodge
STRATHMORE - Wheatland Lodge
SUNDRE - Foothills Retreat Lodge
SYLVAN LAKE - Sylvan Lake Lodge
TABER - Clearview Lodge
THORHILD - Thorhild Lodge
THREE HILLS - Golden Hills Lodge
TOFIELD - Tofield Lodge
TWO HILLS - Hillside Senior Citizens' Lodge
VALLEYVIEW - Red Willow Lodge
VEGREVILLE - The Homestead
VERMILLION- Vermilion Valley
VIKING - Vialta Lodge
VILNA - Vilna Lodge
VULCAN - Peter Dawson Lodge
WAINWRIGHT - Battle River Lodge
WARBURG - Clover Leaf Manor
WESTLOCK - Pembina Lodge
WESTLOCK - Smithfield Lodge
WETASKIWIN - Peace Hills Lodge
WILLINGDON - Eagle Hill Manor
WINFIELD - West Pine Lodge

APPENDIX III

GOVERNMENT OF THE PROVINCE OF ALBERTA

HEALTH FACILITIES REVIEW COMMITTEE ACT

Revised Statutes of Alberta 1980, Chapter H-4
as amended to January 9, 1984

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HEALTH FACILITIES REVIEW COMMITTEE ACT

CHAPTER H-4

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HER MAJESTY, by and with the advice and consent of the Legislative Assembly of Alberta, enacts as follows:

Definitions

1 In this Act,

(a) "Committee" means the Alberta Health Facilities Review Committee and includes a subcommittee established under section 3;

(b) "hospital" means

(i) an approved hospital under *Hospitals Act*,

(ii) any other hospital, institution or other facility for the treatment and care of persons that is owned and operated by the Government of Alberta, except those operated under the administration of the Minister of Social Services and Community Health or those that receive their current operating funds or part of them from a supply vote that is under the administration of a member of the Executive Council other than the Minister of Hospitals and Medical Care,

(ii.1) a mental health hospital under the *Mental Health Act*,

(iii) a contract nursing home as defined in the *Nursing Homes Act*, or

(iv) a home or unit operated under the *Senior Citizens Housing Act;*

(c) "Minister" means the Minister of Hospitals and Medical Care;

(d) "patient", with reference to a home or unit operated under the *Senior Citizens Housing Act*, means a person who resides in that home or unit.

RSA 1980 cH-4 s1; 1981 c72 s10

Committee established

2(1) There is hereby established a committee called the "Alberta Health Facilities Review Committee" consisting of not more than 12 members appointed by the Minister.

(2) The members of the Committee may include members of the Legislative Assembly who are not members of the Executive Council.

(3) An order appointing a member of the Committee may provide for his term of office but in the absence of such a provision, the term of office of a member is one year from the effective date of his appointment and thereafter until his successor is appointed.

(4) The Minister shall designate one of the members of the Committee as chairman and another as a vice-chairman and, unless the order otherwise provides, the term of office of a chairman or vice-chairman so designated is one year from the effective date of the designation and until their respective successors are thereafter designated.

(5) The vice-chairman is the acting chairman of the Committee in the event of the absence or inability to act of the chairman or a vacancy in the office of chairman.

RSA 1980 cH-4 s2; 1983 c81 s4

Sub-committees

3(1) The Committee may

(a) establish one or more sub-committees to perform those duties and functions and exercise those powers of the Committee prescribed by the Committee, and

(b) appoint as members of a sub-committee not less than 3 members of the Committee.

(2) When a sub-committee is established, the Committee shall designate a member of a sub-committee to preside over the sub-committee.

(3) A member of the Committee may be appointed to more than one sub-committee.

(4) A majority of the members appointed to a sub-committee constitute a quorum of the sub-committee.

(5) A decision or other action made or taken by a sub-committee at which its quorum is present is the decision or action of the Committee and binds all members of the Committee.

(6) Two or more sub-committees may act simultaneously.

(7) If a sub-committee is performing a duty or function or exercising its powers and one or more members of the sub-committee are absent during a portion of the time that the sub-committee is performing a duty or function or exercising a power, the remaining members of the sub-committee that are present may, if they constitute a quorum of the sub-committee, perform the duty or function and exercise the power of the sub-committee.

(8) Notwithstanding that a sub-committee is established under this section, the Committee may also perform any duty or function or exercise any power that is prescribed the sub-committee to perform or exercise.

RSA 1980 cH-4 s3

Remuneration and expenses

4 The Minister

(a) may prescribe the rates of remuneration payable to members of the Committee other than those who are employees of the Government or members or employees of an agency of the Government, and

(b) may authorize the payment of travelling and living expenses for members of the Committee while outside their normal place of residence in the course of performing their duties.

RSA 1980 cH-4 s4; 1983 c81 s4

Staff

5(1) The Minister may appoint an employee of the Government under his administration as the Executive Director of the Committee who shall under the direction of the chairman of the Committee assist the Committee in carrying out its duties and functions and exercising its powers.

(2) The Minister shall provide to the Committee the services of employees of the Government under his administration and supplies for the purpose of carrying out secretarial, clerical and related work that the Committee may reasonably require to enable it to carry out its duties and functions and exercise its powers.

RSA 1980 cH-4 s5

Meetings

6 The Committee may, with the approval of the Minister, make rules governing the calling of its meetings, the quorum required at its meetings, the procedure at its meetings, and any other matter relating to the conduct of its business and affairs.

RSA 1980 cH-4 s6; 1983 c81 s4

Visiting hospital

7(1) The Committee shall from time to time visit all hospitals for the purpose of reviewing and inspecting them and the manner in which they are operated.

(2) The Minister may from time to time request the Committee to conduct a visit to a hospital for the purposes of reporting to the Minister on any matter that the Minister specifies in his request.

RSA 1980 cH-4 s7

Investigation of hospital

8 If a complaint is made to the Committee by or on behalf of a patient in a hospital, the Committee shall investigate the care and

treatment and the standards of accommodation received by that patient or any other patient in the hospital.

RSA 1980 cH-4 s8

Entry of hospital

9 For the purpose of carrying out a visit or an investigation under this Act the Committee may enter a hospital at any reasonable hour.

RSA 1980 cH-4 s9

Inspection of hospital records

10(1) The Committee, with respect to a visit or an investigation under this Act, is entitled to access to the records of the hospital for the purpose of inspecting them, making copies of them or taking extracts from them.

(2) Subsection (1) does not apply to

(a) the financial records of the hospital that relate to the operation of the hospital, or

(b) the medical and clinical records of a patient unless the patient or his guardian gives his consent to those records being inspected.

RSA 1980 cH-4 s10

Exemption

11 Nothing in this Act shall be construed as empowering the Committee or other person acting under this Act to inquire into the financial affairs of the hospital that relate to the operation of the hospital.

RSA 19809 cH-4 s11

Persons acting on behalf of Committee

12(1) The Committee may authorize

(a) a member of the Committee to carry out a visit or investigation on behalf of the Committee, or

(b) subject to the approval of the Minister, an employee of the Government under the Minister's administration to carry out a specific inquiry on behalf of the Committee in respect of a visit or investigation.

(2) When a member of the Committee or other person has carried out a visit, investigation or specific inquiry on behalf of the Committee, that member or person shall report his findings to the Committee.

RSA 1980 cH-4 s12

Complaint officer

13(1) The Committee may designate

(a) a member of the Committee, or

(b) with the approval of the Minister, an employee of the Government who is under the administration of the Minister,

as a complaint officer.

(2) The complaint officer shall on behalf of the Committee

(a) make preliminary inquiries, or

(b) if directed to do so by the chairman of the Committee, make investigations

into complaints received under section 8 and report the results of the inquiry or investigation to the Committee.

(3) Members of the Committee at the request of the chairman of the Committee may assist the complaint officer in the carrying out of his duties.

RSA 1980 cH-4 s13

Powers of Committee members

14 A member of the Committee or an employee of the Government carrying out a visit, investigation or other matter on behalf of the Committee has the same powers that the Committee would have if it were carrying out the visit, investigation or other matter.

RSA 1980 cH-4 s14

Court order

15(1) If the Committee, a member of the Committee or an employee of the Government acting on behalf of the Committee is refused entry to a hospital for the purposes of conducting a visit or an investigation, the chairman of the Committee or a person designated by him may apply to the Court of Queen's Bench by originating notice for an order permitting the Committee, member or employee to

(a) enter the hospital at any reasonable hour and conduct the visit or investigation, and

(b) require the production of any records of the hospital, other than those referred to in section 10(2).

(2) An application under subsection (1) may be made ex parte, if the Court considers it proper to do so in the circumstances.

RSA 19809 cH-4 s15

Annual report

16(1) As soon as possible after the end of each year, the Committee shall prepare and submit to the Minister a report summarizing its activities in that year.

(2) On receiving a report under subsection (1), the Minister shall lay a copy of the report before the Legislative Assembly if it is then in session, and if not, within 15 days after the commencement of the next ensuing session.

RSA 1980 cH-4 s16

Act binds Crown

17 This Act binds the Crown.

RSA 1980 cH-4 s17